Medicaid ACH-PCS Cost Settlement

Adult Care Home with Special Care Unit Beds

2005 - 2006

REPORT DUE DATE: JANUARY 31, 2007

Facility Name: _____ Facility Address: _____

County: _____ City, State, Zip Code: _____

License Number: _____ Medicaid Provider Number: _____

FID Number: _____ Cost Reporting Period: From _____ Through _____

Line #	ITEM		AMOUNTS
1.	Total: Personal Care Service Cost		1.
2.	Total: Health Services		2.
3.	Total: Initial/Orientation Aide Training		3.
4.	**Add:**	**[Line #1 plus Line #2 plus Line #3]**	
5.	Total: Facility Costs minus Administration Cost		5.
6.	Total Administration Cost		6.
7.	Administration Cost Factor	**[Divide Line #6 by Line #5]**	
8.	Loaded PCS Costs	**[Multiply Line #4 by (Line #7 + 1.00)]**	
9.	Resident Days		9.
10.	SA (Medicaid) Days		10.
11.	Medicaid %	**[Divide Line #10 by Line #9]**	
12.	Medicaid Loaded PCS Cost	**[Multiply Line #8 by Line #11]**	
13.	Medicaid PCS Payment		13.
14.	Balance Now Due:	**[Line #13 minus Line #12 but do not enter less than $ 0.00**	

Line # Cost Report Schedule References

1. Schedule C, Line 60, Column 7
2. Schedule C, Line 80, Column 7
3. Schedule C, Line 90, Column 7
5. Schedule C, Line 240, Column 7 minus Schedule C, Line 120, Column 7
6. Schedule C, Line 120, Column 7
9. Schedule A, Line 19
10. Schedule A, Line 20
13. Schedule B, Line 4, Column 5

Signature of person filling out the form: _____

Telephone Number: _____

MAIL FORM AND BALANCE DUE PAYABLE TO:

Division of Medical Assistance
Attention: Elizabeth Grady
2501 Mail Service Center
Raleigh, NC 27699-2501
Phone (919) 855-4207 Fax (919) 715-2209